CHANGE OF ADDRESS FORM

Attn: COBRA Coordinator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the COBRA Coordinator of the EUTF's group health plan(s) of a change in the mailing address of an employee, Qualified Beneficiary or other Plan Participant. The individuals identified below reside at the addresses shown below as of the date of this Form.

_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Signature of Employee	Date
_____	_____
Name of Employee	Social Security Number of Employee